90 Degree Benefits
A Turn For The Better

291 S. Lambert Road, Suite 4, Orange, CT 06477
Phone: (203) 876-1660 Fax: (203) 877-9558
https://90degreesbp.lh1ondemand.com

FLEXIBLE SPENDING ACCOUNT (FSA) REQUEST FOR REIMBURSEMENT FORM

Why fill out a reimbursement form?? ***Download our Mobile App*** *to easily upload your claim and receipts*
Search ***My 90DB HSA FSA*** *from your Android or iOS store*

Employer: **Simsbury Public School**

EMPLOYEE INFORMATION

Name: _____ Date of Birth: _____

Home Address: _____

Email Address: _____ Phone: _____

A. HEALTH CARE EXPENSES - Attach Supporting Documentation

(Cancelled checks, bank statements and credit card receipts are not acceptable documentation)

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Amount of Reimbursement Requested
		TOTAL HEALTH CARE EXPENSE		

B. DAY (DEPENDENT) CARE EXPENSES – Attach Supporting Documentation - Dependent Care receipts must be from the day care provider *(self-substantiation is not allowed)* and must include the child(ren)s name, age, dates of service, the charge for the dates of service, provider's name, address and **SSN or Federal Tax ID#.**

(Cancelled checks, bank statements and credit card receipts are not acceptable documentation)

Name of Dependent(s) and Age(s)	Service Date		Name, Address and Social Security Number Or Tax Identification Number of Provider of Service	Amount of Reimbursement Requested
	From	To		
		* TOTAL DEPENDENT CARE EXPENSE		

* NOTE: The total amount claimed under the plan for any coverage period must not exceed the lesser of your earned income for the plan year or the earned income of your spouse. Please read your Summary Plan Description carefully for additional information.

EMPLOYEE SIGNATURE REQUIRED – *READ CAREFULLY*

I certify that the statement and information on this reimbursement form are accurate and true. I also certify that I am claiming reimbursement for only eligible expenses incurred during the plan year and only for eligible plan participants. I certify that these expenses have not been or will not be reimbursed under this or any other benefit plan. I further certify I will not claim these or any other expenses reimbursed through this plan, as an income tax deduction and I assume all liability for taxes and penalties out of any disallowed deduction/credit.

_____ _____

Employee's Signature Date

Send this form and supporting documentation to: CDHPClaims@90DegreeBenefits.com or Fax to 203-877-9558 or mail to 291 S. Lambert Road Suite 4, Orange, CT 06477

You may also enter your claim and upload your receipts on our secure website: https://90degreesbp.lh1ondemand.com/

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Flexible Spending Account Claim Filing Tips

Health Care Accounts – *Employee and Dependent Health Care Expenses **Not Covered** by Insurance*

1. **ALWAYS** submit a completed "Flexible Spending Account Request for Reimbursement" claim form.

2. **If your claim may be reimbursable through your health care plan (medical, dental, vision, etc.), ALWAYS submit the charges to that Plan first. When you receive your "Explanation of Benefits" (EOB) that indicates the non-reimbursable expenses, attach it to the Flex claim form and mail to 90 Degree Benefits, Inc.**

3. For all other expenses, attach to the claim form a bill or receipt that provides **ALL** of the following information:

    a. Date the expense was incurred **(not when payment is made)**;
    b. Name and address of the provider of service or supply;
    c. Itemized charges; and
    d. Name of person for whom the expense was incurred.

Note: ***"Paid on Account" statements, "Balance Due" bills, canceled checks, and credit card vouchers are NOT acceptable documentation. Acceptable documentation is described in numbers 2 and 3 above.***

Dependent Day Care Accounts – *Day Care Expenses for Child/Elder Dependents of Employees*

1. **ALWAYS** submit a completed "Flexible Spending Account Request for Reimbursement" claim form.

2. Provide **ALL** of the following information:

    a. Dependent's name;
    b. Receipt showing date of service, **(not when payment is made)**;
    c. Name, address and **Tax Identification Number (or Social Security Number)** of the provider of the day care service); and
    d. Amount paid for the day care service.

Note: Canceled checks, bank statements and credit card receipts are not acceptable documentation.

PLEASE KEEP THIS FOR YOUR RECORDS

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